THIS DECISION HAS BEEN APPEALED. THE FOLLOWING IS THE RELATED SOAH DECISION NUMBER:

SOAH DOCKET NO. 453-04-4570.M5

MDR Tracking Number: M5-04-0735-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution - General and 133.308 titled Medical Dispute Resolution by Independent Review Organizations, the Medical Review Division assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. The dispute was received on 11-06-03.

The Medical Review Division has reviewed the enclosed IRO decision and determined that **the requestor did not prevail** on the issues of medical necessity. The IRO agrees with the previous determination that the electrical stimulation, joint mobilization, myofascial release, therapeutic exercises, therapeutic activities, durable medical equipment, office visits and neuromuscular stimulator were not medically necessary. Therefore, the requestor is not entitled to reimbursement of the IRO fee.

Based on review of the disputed issues within the request, the Medical Review Division has determined that medical necessity fees were the only fees involved in the medical dispute to be resolved. As the services listed above were not found to be medically necessary, reimbursement for dates of service 02-10-03 through 02-28-03 are denied and the Medical Review Division declines to issue an Order in this dispute.

This Findings and Decision is hereby issued this 23rd day of February 2004.

Debra L. Hewitt
Medical Dispute Resolution Officer
Medical Review Division

DLH/dlh

IRO Certificate #4599

NOTICE OF INDEPENDENT REVIEW DECISION amended

February 16, 2004

Re: IRO Case # M5-04-0735-01

Texas Worker's Compensation Commission:

___ has been certified as an independent review organization (IRO) and has been authorized to perform independent reviews of medical necessity for the Texas Worker's Compensation Commission (TWCC). Texas HB. 2600, Rule133.308 effective January 1, 2002, allows a claimant or provider who has received an adverse medical necessity determination from a carrier's internal process, to request an independent review by an IRO.

In accordance with the requirement that TWCC assign cases to certified IROs, TWCC assigned this case to ___ for an independent review. ___ has performed an independent review of the proposed care to determine if the adverse determination was appropriate. For that purpose, ___ received relevant medical records, any documents obtained from parties in making the adverse determination, and any other documents and/or written information submitted in support of the appeal.

The case was reviewed by a physician who is Board Certified in Orthopedic Surgery, and who has met the requirements for TWCC Approved Doctor List or has been approved as an exception to the Approved Doctor List. He or she has signed a certification statement attesting that no known conflicts of interest exist between him or her and any of the treating physicians or providers, or any of the physicians or providers who reviewed the case for a determination prior to referral to ___ for independent review. In addition, the certification statement further attests that the review was performed without bias for or against the carrier, medical provider, or any other party to this case.

The determination of the ___ reviewer who reviewed this case, based on the medical records provided, is as follows:

> History
> The patient is a 73-year-old female who injured her right shoulder in ___ when she attempted to lift a 50-pound bag over her shoulder and felt immediate pain in the lateral aspect of her shoulder. She was treated conservatively, but continued to have significant pain. The patient received a CT scan and presumably an MRI that demonstrated pathology. Ultimately the patient underwent right shoulder arthroscopic decompression, AC joint

resection, labral repair and rotator cuff tear debridement followed by postoperative rehabilitation. The patient underwent surgery on 10/16/02. Postoperative chiropractic/physical therapy began on 10/21/02 and continued for sixty sessions through 2/28/03.

Requested Service(s)
Electrical stimulation-unattended, joint mobilization, myofascial release, therapeutic exercises, durable medical equipment, OV-established patient, neuromuscular stimulator, therapeutic activities 2/10/03-2/28/03

Decision
I agree with the carrier's decision to deny the requested services.

Rationale
The patient received excessive postoperative rehabilitation and because of her age she progressed very slowly. However, physical therapy treatment beyond the treatment that had been approved appears to have been excessive, based on the records provided for this review. The patient should have been easily transferred to a home exercise program. Based on the patient's age and the level of pathology found at surgery, it could be anticipated that the patient would take greater than one year to achieve maximal rehabilitation from surgical intervention. In addition, she will most likely suffer from permanent loss of motion or strength because of her age and the amount of pathology. However, chiropractic or physical therapy is not indicated during this long, extended course after a surgical procedure. The records provided for this review failed to demonstrate the necessity for physical therapy or chiropractic treatment with modalities during the period in dispute.

This medical necessity decision by an Independent Review Organization is deemed to be a Commission decision and order.

_____